House of Representatives

General Assembly

File No. 137

January Session, 2013

Substitute House Bill No. 6461

House of Representatives, March 25, 2013

The Committee on Aging reported through REP. SERRA of the 33rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 17b-342 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The Commissioner of Social Services shall administer the Connecticut home-care program for the elderly state-wide in order to prevent the institutionalization of elderly persons (1) who are recipients of medical assistance, (2) who are eligible for such assistance, (3) who would be eligible for medical assistance if residing in a nursing facility, or (4) who meet the criteria for the state-funded portion of the program under subsection **[**(i)**]** (j) of this section. For purposes of this section, a long-term care facility is a facility which has been federally certified as a skilled nursing facility or intermediate care facility. The commissioner shall make any revisions in the state Medicaid plan required by Title XIX of the Social Security Act prior to implementing the program. The annualized cost of the community-

based services provided to such persons under the program shall not exceed sixty per cent of the weighted average cost of care in skilled nursing facilities and intermediate care facilities. The program shall be structured so that the net cost to the state for long-term facility care in combination with the community-based services under the program shall not exceed the net cost the state would have incurred without the program. The commissioner shall investigate the possibility of receiving federal funds for the program and shall apply for any necessary federal waivers. A recipient of services under the program, and the estate and legally liable relatives of the recipient, shall be responsible for reimbursement to the state for such services to the same extent required of a recipient of assistance under the state supplement program, medical assistance program, temporary family assistance program or supplemental nutrition assistance program. Only a United States citizen or a noncitizen who meets the citizenship requirements for eligibility under the Medicaid program shall be eligible for home-care services under this section, except a qualified alien, as defined in Section 431 of Public Law 104-193, admitted into the United States on or after August 22, 1996, or other lawfully residing immigrant alien determined eligible for services under this section prior to July 1, 1997, shall remain eligible for such services. Qualified aliens or other lawfully residing immigrant aliens not determined eligible prior to July 1, 1997, shall be eligible for services under this section subsequent to six months from establishing residency. Notwithstanding the provisions of this subsection, any qualified alien or other lawfully residing immigrant alien or alien who formerly held the status of permanently residing under color of law who is a victim of domestic violence or who has mental retardation shall be eligible for assistance pursuant to this section. Qualified aliens, as defined in Section 431 of Public Law 104-193, or other lawfully residing immigrant aliens or aliens who formerly held the status of permanently residing under color of law shall be eligible for services under this section provided other conditions of eligibility are met.

(b) The commissioner shall solicit bids through a competitive process and shall contract with an access agency, approved by the

Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection [(e)] (n) of this section, that submits proposals which meet or exceed the minimum bid requirements. In addition to such contracts, the commissioner may use department staff to provide screening, coordination, assessment and monitoring functions for the program.

(c) The community-based services covered under the program shall include, but not be limited to, the following services to the extent that they are not available under the state Medicaid plan, occupational therapy, homemaker services, companion services, meals on wheels, adult day care, transportation, mental health counseling, care management, elderly foster care, minor home modifications and assisted living services provided in state-funded congregate housing and in other assisted living pilot or demonstration projects established under state law. Personal care assistance services shall be covered under the program to the extent that (1) such services are not available under the Medicaid state plan and are more cost effective on an individual client basis than existing services covered under such plan, and (2) the provision of such services is approved by the federal government. Recipients of state-funded services pursuant to subsection (j) of this section and persons who are determined to be functionally eligible for community-based services who have an application for medical assistance pending and are determined presumptively eligible for Medicaid pursuant to subsection (e) of this section, shall have the cost of home health and community-based services covered by the program, provided they comply with all medical assistance application requirements. Access agencies shall not use department funds to purchase community-based services or home health services from themselves or any related parties.

(d) Physicians, hospitals, long-term care facilities and other licensed health care facilities may disclose, and, as a condition of eligibility for the program, elderly persons, their guardians, and relatives shall disclose, upon request from the Department of Social Services, such

financial, social and medical information as may be necessary to enable the department or any agency administering the program on behalf of the department to provide services under the program. Long-term care facilities shall supply the Department of Social Services with the names and addresses of all applicants for admission. Any information provided pursuant to this subsection shall be confidential and shall not be disclosed by the department or administering agency.

[(e) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to define "access agency", to implement and administer the program, to establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process and to specify conditions of eligibility.**]**

(e) Not later than October 1, 2013, the Commissioner of Social Services, in consultation with the Commissioner on Aging, shall establish a system under which the state will fund services under the Connecticut home-care program for the elderly for a period of up to ninety days for applicants who require a skilled level of nursing care and who are determined to be presumptively eligible for Medicaid coverage. Such system shall include, but not be limited to: (1) The development of a preliminary screening tool to be used by representatives of the access agency selected pursuant to subsection (b) of this section to determine whether an applicant is functionally able to live at home or in a community setting and is likely to be financially eligible for Medicaid; (2) authorization by the Commissioner of Social Services for such access agency representatives to initiate home-care services not later than five days after such functional eligibility determination for applicants deemed likely to be eligible for Medicaid; (3) a presumptive financial Medicaid eligibility determination for such applicants by the Department of Social Services not later than seventy-two hours after the functional eligibility determination; and (4) a written agreement to be signed by such applicant attesting to the accuracy of financial and other information such applicant provides and acknowledging that (A) state-funded services shall be provided not later than ninety days after the date on which the applicant applies

for Medicaid coverage, and (B) such applicant shall complete a Medicaid application on the date such applicant is screened for functional eligibility or not later than ten days after such screening. The Department of Social Services shall make a final determination as to Medicaid eligibility for presumptive Medicaid eligibility applicants not later than forty-five days after receipt of a completed Medicaid application from such applicant.

(f) Pursuant to section 1560.10 of the Department of Social Services' uniform policy manual, the Commissioner of Social Services shall retroactively apply a final determination of Medicaid eligibility for presumptive Medicaid eligibility applicants. The commissioner shall request available federal matching Medicaid funds for state costs during the ninety-day presumptive Medicaid eligibility period for applicants determined to be eligible for Medicaid coverage. The commissioner, in consultation with the Commissioner on Aging, shall identify funding pursuant to the federal Older Americans Act of 1965, as amended from time to time, that may be allocated to subsidize costs during the presumptive eligibility period for those applicants who are not determined eligible for Medicaid. State costs during the presumptive eligibility period shall be offset by available federal Medicaid reimbursements and savings realized for institutional care that would have been necessary but for the presumptive Medicaid eligibility system.

[(f)**]** (g) The commissioner may require long-term care facilities to inform applicants for admission of the Connecticut home-care program for the elderly established under this section and to distribute such forms as the commissioner prescribes for the program. Such forms shall be supplied by and be returnable to the department.

[(g)**]** (h) The commissioner shall report annually, by June first, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the Connecticut home-care program for the elderly in such detail, depth and scope as said committee requires

to evaluate the effect of the program on the state and program participants. Such report shall include information on (1) the number of persons diverted from placement in a long-term care facility as a result of the program, (2) the number of persons screened, (3) the average cost per person in the program, (4) the administration costs, (5) the estimated savings, and (6) a comparison between costs under the different contracts.

[(h)**]** (i) An individual who is otherwise eligible for services pursuant to this section shall, as a condition of participation in the program, apply for medical assistance benefits pursuant to section 17b-260 when requested to do so by the department and shall accept such benefits if determined eligible.

[(i)**]** (j) (1) On and after July 1, 1992, the Commissioner of Social Services shall, within available appropriations, administer a state-funded portion of the Connecticut home-care program for the elderly for persons (A) who are sixty-five years of age and older and who are not eligible for Medicaid; (B) who are inappropriately institutionalized or at risk of inappropriate institutionalization; (C) whose income is less than or equal to the amount allowed under subdivision (3) of subsection (a) of this section; and (D) whose assets, if single, do not exceed the minimum community spouse protected amount pursuant to **[**Section**]** section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed one hundred fifty per cent of said community spouse protected amount and on and after April 1, 2007, whose assets, if single, do not exceed one hundred fifty per cent of the minimum community spouse protected amount pursuant to **[**Section**]** section 4022.05 of the department's uniform policy manual or, if married, the couple's assets do not exceed two hundred per cent of said community spouse protected amount.

(2) Except for persons residing in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e, as provided in subdivision (3) of this subsection, any person whose income is at or below two hundred per cent of the federal

poverty level and who is ineligible for Medicaid shall contribute seven per cent of the cost of his or her care. Any person whose income exceeds two hundred per cent of the federal poverty level shall contribute seven per cent of the cost of his or her care in addition to the amount of applied income determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(3) Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income is at or below two hundred per cent of the federal poverty level, shall not be required to contribute to the cost of care. Any person who resides in affordable housing under the assisted living demonstration project established pursuant to section 17b-347e and whose income exceeds two hundred per cent of the federal poverty level, shall contribute to the applied income amount determined in accordance with the methodology established by the Department of Social Services for recipients of medical assistance. Any person whose income exceeds two hundred per cent of the federal poverty level and who does not contribute to the cost of care in accordance with this subdivision shall be ineligible to receive services under this subsection. Notwithstanding any provision of the general statutes, the department shall not be required to provide an administrative hearing to a person found ineligible for services under this subsection because of a failure to contribute to the cost of care.

(4) The annualized cost of services provided to an individual under the state-funded portion of the program shall not exceed fifty per cent of the weighted average cost of care in nursing homes in the state, except an individual who received services costing in excess of such

amount under the Department of Social Services in the fiscal year ending June 30, 1992, may continue to receive such services, provided the annualized cost of such services does not exceed eighty per cent of the weighted average cost of such nursing home care. The commissioner may allow the cost of services provided to an individual to exceed the maximum cost established pursuant to this subdivision in a case of extreme hardship, as determined by the commissioner, provided in no case shall such cost exceed that of the weighted cost of such nursing home care.

[(j)**]** (k) The Commissioner of Social Services may implement revised criteria for the operation of the program while in the process of adopting such criteria in regulation form, provided the commissioner prints notice of intention to adopt the regulations in the Connecticut Law Journal within twenty days of implementing the policy. Such criteria shall be valid until the time final regulations are effective.

[(k)**]** (l) The commissioner shall notify any access agency or area agency on aging that administers the program when the department sends a redetermination of eligibility form to an individual who is a client of such agency.

[(l)**]** (m) In determining eligibility for the program described in this section, the commissioner shall not consider as income Aid and Attendance pension benefits granted to a veteran, as defined in section 27-103, or the surviving spouse of such veteran.

(n) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to (1) define "access agency", (2) implement and administer the program, (3) implement and administer the presumptive Medicaid eligibility system, (4) establish uniform state-wide standards for the program and a uniform assessment tool for use in the screening process, and (5) specify conditions of eligibility.

Sec. 2. Subsection (a) of section 17b-253 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective*

October 1, 2013):

(a) The Department of Social Services shall seek appropriate amendments to its Medicaid regulations and state plan to allow protection of resources and income pursuant to section 17b-252. Such protection shall be provided, to the extent approved by the federal Centers for Medicare and Medicaid Services, for any purchaser of a precertified long-term care policy and shall last for the life of the purchaser. Such protection shall be provided under the Medicaid program or its successor program. Any purchaser of a precertified long-term care policy shall be guaranteed coverage under the Medicaid program or its successor program, to the extent the individual meets all applicable eligibility requirements for the Medicaid program or its successor program. Until such time as eligibility requirements are prescribed for Medicaid's successor program, for the purposes of this subsection, the applicable eligibility requirements shall be the Medicaid program's requirements as of the date its successor program was enacted. The Department of Social Services shall count insurance benefit payments toward resource exclusion to the extent such payments (1) are for services paid for by a precertified long-term care policy; (2) are for the lower of the actual charge and the amount paid by the insurance company; (3) are for nursing home care, or formal services delivered to insureds in the community as part of a care plan approved by an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined in regulations adopted pursuant to subsection **[**(e)**]** (n) of section 17b-342, as amended by this act; and (4) are for services provided after the individual meets the coverage requirements for long-term care benefits established by the Department of Social Services for this program. The Commissioner of Social Services shall adopt regulations, in accordance with chapter 54, to implement the provisions of this subsection and sections 17b-251, 17b-252, 17b-254 and 38a-475, as amended by this act, relating to determining eligibility of applicants for Medicaid, or its successor program, and the coverage requirements for long-term care benefits.

Sec. 3. Subdivision (1) of subsection (g) of section 17b-354 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(g) (1) A continuing care facility which guarantees life care for its residents, as defined in subsection (b) of this section, (A) shall arrange for a medical assessment to be conducted by an independent physician or an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined by regulations adopted pursuant to subsection **[**(e)**]** (n) of section 17b-342, as amended by this act, prior to the admission of any resident to the nursing facility and shall document such assessment in the resident's medical file, and (B) may transfer or discharge a resident who has intentionally transferred assets in a sum which will render the resident unable to pay the cost of nursing facility care in accordance with the contract between the resident and the facility.

Sec. 4. Subsection (a) of section 17b-617 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2013*):

(a) The Commissioner of Social Services shall, within available appropriations, establish and operate a state-funded pilot program to allow not more than fifty persons with disabilities (1) who are age eighteen to sixty-four, inclusive, (2) who are inappropriately institutionalized or at risk of inappropriate institutionalization, and (3) whose assets do not exceed the asset limits of the state-funded home care program for the elderly, established pursuant to subsection **[**(i)**]** (j) of section 17b-342, as amended by this act, to be eligible to receive the same services that are provided under the state-funded home care program for the elderly. At the discretion of the Commissioner of Social Services, such persons may also be eligible to receive services that are necessary to meet needs attributable to disabilities in order to allow such persons to avoid institutionalization.

Sec. 5. Section 38a-475 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective October 1, 2013*):

The Insurance Department shall only precertify long-term care insurance policies which (1) alert the purchaser to the availability of consumer information and public education provided by the Department of Social Services pursuant to section 17b-251; (2) offer the option of home and community-based services in addition to nursing home care; (3) in all home care plans, include case management services delivered by an access agency approved by the Office of Policy and Management and the Department of Social Services as meeting the requirements for such agency as defined in regulations adopted pursuant to subsection **[**(e)**]** (n) of section 17b-342, as amended by this act, which services shall include, but need not be limited to, the development of a comprehensive individualized assessment and care plan and, as needed, the coordination of appropriate services and the monitoring of the delivery of such services; (4) provide inflation protection; (5) provide for the keeping of records and an explanation of benefit reports on insurance payments which count toward Medicaid resource exclusion; and (6) provide the management information and reports necessary to document the extent of Medicaid resource protection offered and to evaluate the Connecticut Partnership for Long-Term Care. No policy shall be precertified if it requires prior hospitalization or a prior stay in a nursing home as a condition of providing benefits. The commissioner may adopt regulations, in accordance with chapter 54, to carry out the precertification provisions of this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2013*	17b-342
Sec. 2	*October 1, 2013*	17b-253(a)
Sec. 3	*October 1, 2013*	17b-354(g)(1)
Sec. 4	*October 1, 2013*	17b-617(a)
Sec. 5	*October 1, 2013*	38a-475

Statement of Legislative Commissioners:
Technical changes were made in subsections (e), (f) and (g) of section 1 for accuracy and sections 2 to 5, inclusive, were added for accuracy and uniformity.

AGE *Joint Favorable Subst. -LCO*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect
Department of Social Services	GF - See Below

Municipal Impact: None

Explanation

This bill requires the Department of Social Services (DSS) to implement presumptive eligibility for the Connecticut Home Care Program (CHCP) under Medicaid. An individual granted presumptive eligibility would receive up to 90 days of care while their eligibility was determined. This would result in three distinct impacts, as detailed below.

First, the state would incur a one-time cost due to the acceleration of eligibility determinations and the provision of benefits sooner. Currently, clients do not receive Medicaid benefits while pending eligibility determinations, which can take significant amounts of time. While the average time to determine eligibility for the program is not known, it is reasonable to assume it could be longer than 90 days.

In FY 12, the CHCP averaged 196 admissions per month, with a per diem cost of $58. Therefore, accelerating the eligibility for these clients by 90 days would result in a one-time cost of $2.1 million.

Second, the state would incur an ongoing cost related to providing benefits for clients who are eventually determined ineligible for Medicaid. It is not known what percentages of CHCP applications are found to be ineligible for Medicaid. If it is assumed that the 196

monthly admissions noted above are the result of a 90% eligibility success rate, it would indicate that 21 monthly applications would be found ineligible. Therefore, 90 days of care for ineligible clients would have an annualized cost of $1.2 million.

The bill specifies that DSS must seek available funding under the federal Older Americans Act to offset state costs incurred for providing care to those eventually deemed ineligible. It is not known whether any funds exist for this purpose.

Third, there is a potential savings if the provision of home care services during the eligibility determination process prevents or delays admission to a more expensive, Medicaid funded care setting, such as a nursing home. It cannot be known how many clients may be affected. Although a person is not receiving home care services from the Medicaid program, they may be receiving in-kind care from family members or care paid for from other resources. The average Medicaid cost per day for a nursing home stay is $205. Therefore, for a 90 day episode of care, receiving services under the CHCP rather than a nursing home would result in a savings of $13,230 per person.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Department of Social Services Caseload Information

OLR Bill Analysis

sHB 6461

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR THE CONNECTICUT HOME-CARE PROGRAM FOR THE ELDERLY.

SUMMARY:

This bill requires the Department of Social Services (DSS) commissioner to implement presumptive eligibility for individuals applying to the Medicaid-funded portion of the Connecticut Home Care Program for Elders (CHCPE). He must do this in consultation with the aging commissioner (who has not been appointed) by October 1, 2013.

Presumptive eligibility allows an applicant to be determined immediately eligible for enrollment in CHCPE without initially requiring a full Medicaid-eligibility determination. Under the bill, the state will pay for up to 90 days of care for applicants who (1) require a skilled nursing home level of care and (2) are determined presumptively eligible for Medicaid.

During the 90-day presumptive eligibility period, state costs must be offset by (1) available federal Medicaid reimbursements and (2) savings realized from providing home- and community-based care instead of institutional care that would have been necessary without presumptive eligibility.

The bill requires the DSS commissioner to adopt regulations to implement and administer the new system.

EFFECTIVE DATE: October 1, 2013

PRESUMPTIVE ELIGIBILITY SYSTEM

Eligibility Determinations

By law, DSS contracts with "access" agencies (currently three) to determine CHCPE participants' service needs and develop individualized care plans. The bill requires the commissioner to develop a screening tool for these agencies to use to determine if a presumptive eligibility applicant is (1) functionally able to live in a home or community setting and (2) likely to be financially eligible for Medicaid. The commissioner must authorize these agencies to initiate home care services within five days of making this determination. DSS must then make a presumptive financial eligibility determination within 72 hours after the functional eligibility determination is completed.

Written Agreement

The bill requires applicants to sign a written agreement attesting to the accuracy of the information they provide. The agreement must also acknowledge that applicants will (1) receive state-funded services within 90 days of applying for Medicaid coverage and (2) complete a Medicaid application on the day they are screened for functional eligibility, or no later than 10 days after the screening.

DSS must make a final Medicaid-eligibility determination for presumptive eligibility applicants within 45 days of receiving a completed Medicaid application.

Offsetting State Costs

For presumptive eligibility applicants deemed Medicaid-eligible, the bill requires the DSS commissioner to retroactively apply the final eligibility determination and request all available federal matching funds to cover state costs during the presumptive eligibility period.

For applicants deemed Medicaid-ineligible, the DSS commissioner must consult with the aging commissioner and identify federal Older Americans Act funding that may be allocated to subsidize state costs during this period.

BACKGROUND

CHCPE

CHCPE is a Medicaid waiver and state-funded program that provides home- and community-based services for qualifying individuals ages 65 and older who are institutionalized or at risk of institutionalization. Services include care management, adults day and foster care, personal care assistance, homemaker services, transportation, meals-on-wheels, minor home modifications, and certain assisted living services.

COMMITTEE ACTION

Aging Committee

Joint Favorable
Yea 12 Nay 0 (03/07/2013)